MICHIGAN MENTAL HEALTH COMMISSION REPORT

(FY2006 Appropriation Bill - Public Act 154 of 2005)

April 15, 2006

Section 458: By April 15, 2006, the department shall provide each of the following to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director: (a) An updated plan for implementing recommendations of the Michigan mental health commission made in the commission's report dated October 15, 2004. (b) A report that evaluates the cost-benefit of establishing secure residential facilities of fewer than 17 beds for adults with serious mental illness, modeled after such programming in Oregon or other states. (c) In conjunction with the state court administrator's office, a report that evaluates the cost-benefit of establishing a specialized mental health court program that diverts adults with serious mental illness alleged to have committed an offense deemed nonserious into treatment prior to the filing of any charges.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor
Janet Olszewski, Director

JENNIFER GRANHOLM
GOVERNOR

DEPARTMENT OF COMMUNITY HEALTH

JANET OLSZEWSKI
DIRECTOR

A REPORT TO COMPLY WITH THE REQUIREMENTS IN SECTION 458 OF PUBLIC ACT 154
UPDATED PLAN FOR IMPLEMENTATION OF MENTAL HEALTH COMMISSION RECOMMENDATIONS

BACKGROUND: THE MICHIGAN MENTAL HEALTH COMMISSION

In December 2003, Governor Granholm issued Executive Order 2003-24, establishing the Michigan Mental Health Commission (MMHC). The broad charge given to the MMHC by the Governor was to identify and prioritize pressing issues, examine options for change, and make recommendations to improve publicly supported mental health services. The MMHC was composed of 29 appointed voting members and 3 non-voting ex-officio members. The Commission convened in February 2004 and numerous general, public hearing, and sub-committee meetings were held over the next eight months. In late October 2004, the Commission submitted its Final Report to the Governor.

In the Report, the MMHC summarized current problems related to mental health care in the state, and offered an expansive vision for a transformed mental health system in Michigan, a vision buttressed by a compelling set of values, and amplified through 7 core goals and 71 specific recommendations. In a companion Implementation Guide published in November 2004, the Commission outlined necessary actions and projected time-frames for each of the 71 recommendations.

In April 2005, the Michigan Department of Community Health (MDCH) issued its initial plan for implementation of Commission recommendations. The MDCH plan *prioritized a subset* of the 71 recommendations for initial implementation activity. The recommendations prioritized for implementation were those that directly related to certain critical issues confronting the public mental health system. MDCH also added items (e.g., state hospitals; forensic considerations; etc.) to its action plan that had not been fully addressed in the Commission's deliberations and recommendations.

MMHC RECOMMENDATIONS: IMPLEMENTATION ACTIVITIES AND DEVELOPMENTS

In the period following publication of the Commission's Final Report, there have been ongoing activities and accomplishments directed toward preserving, improving and enhancing the state's public mental health system, consistent with both the general direction and specific recommendations of the Michigan Mental Health Commission's Final Report.

Legislation: Just prior to the end of 2004, Governor Granholm signed legislation that created new options for individuals with serious mental illnesses. "Kevin's Law" - a four-bill package - amended the Mental Health Code to provide for Assisted Outpatient Treatment (AOT) under court order. Other legislation - a series of bills to promote the use of "Advance Psychiatric

Directives" (APD) - enabled individuals with serious mental illness to designate a "patient advocate" to make decisions regarding mental health treatment, consistent with the person's statement regarding their choices and preferences for care, in the event that the individual is unable to give informed consent for treatment in the future. MDCH has provided information, education, forms and other materials to help consumers understand and utilize APD[1]. *Addresses elements of MMHC recommendations #6 (hierarchy of choice) and #70 (encouraging the establishment of advance directives).*

Funding: Both the FY 05-06 and the FY 06-07 appropriations for mental health contained substantial increases to the Medicaid mental health funding line, utilizing an innovative provider assessment as part of the financing arrangement. *Addresses elements of MMHC recommendation #39 (new funding strategy).*

Specialty Service Waiver: During 2005, MDCH was immersed in the task of renewing Michigan's 1915(b) Medicaid specialty services waiver for mental health, developmental disabilities and substance abuse services. The waiver (which has been assessed as a "promising practice" in system reform[2] by the Centers for Medicare and Medicaid Services, commonly referred to as "CMS") is an integral part of the programmatic and fiscal infrastructure of the public mental health system in Michigan. CMS ultimately renewed the waiver for an additional two-year period. The waiver renewal added – as a Medicaid covered service – "peer specialist" activities, allowing consumers to provide support, mentoring and assistance to other individuals with mental illness, to foster recovery and community inclusion. Training has already been provided to groups of peer specialists, using a model first established by the state of Georgia, and a number of peer-specialists have been certified using this model. *Addresses elements of MMHC recommendation #39 (full and flexible use of federal funds; preserving growth potential and maintaining actuarial soundness of any capitation system).*

Children's SED Waiver: In addition to the renewal of the 1915(b) specialty services waiver, MDCH submitted and received approval for a 1915(c) home and community-based services waiver for seriously emotionally disturbed children and adolescents. This unique waiver, one of only a handful approved by CMS, extends specialty care to additional children and adolescents in participating counties who might not have previously qualified for Medicaid specialized mental health services. *Addresses elements of MMHC recommendation #39 (blended funding; organize local sources of funding to access additional federal matching dollars).*

Evidence-Based Practices: MDCH has continued to emphasize, support, and finance the dissemination and use of evidence-based practices (EBP) in mental health care. The department had previously established an EBP "steering committee" composed of Community Mental Health Services Programs (CMHSPs), university researchers, and consumer representatives. The steering committee has provided leadership in advocating for and disseminating evidence-based mental health care models throughout the public system. As part of this broad-based effort, the committee planned - and MDCH and the Michigan Association of Community Mental Health Boards (MACMHB) sponsored - a two-day conference in May 2005 on Evidence-Based Practices, which attracted over 800 attendees. As a follow-up to this "kick-off" conference, MDCH issued a Request for Proposal (RFP) to CMHSPs, offering funds for the development of an organizational infrastructure to support

[1] See http://www.michigan.gov/mdch/0,1607,7-132-2941_4868_41752---,00.html
[2] See http://www.cms.hhs.gov/promisingpractices/mimsss.pdf

diffusion and implementation of selected evidence-based mental health practices. The department subsequently awarded grants to 18 CMHSPs (those CMHSPs that serve as Prepaid Inpatient Health Plans [PIHPs] under the Medicaid specialty services waiver) for infrastructure development and for implementation of particular nationally recognized EBPs (Family Psychoeducation, Integrated Treatment for Co-Occurring Disorders, and Parent Management Training), and to improve clinical practices across the organizations and their respective service networks. *Addresses elements of MMHC recommendation #36 (adoption of evidence-based practices).*

Medication Quality Improvement Initiative: Promotion of evidence-based practices was extended to the utilization of psychotropic drugs through the MDCH Pharmacy Quality Improvement Project (PQIP). A collaborative public-private partnership, PQIP provides analyses of medication prescribing patterns and offers consultation and education to providers. In a similar vein, the department has participated in and supported the Michigan Medication Algorithm Project (MMAP), sponsored by the Flinn Foundation, to improve the quality of psychotropic prescribing patterns through the use of evidence-based guidelines. Two CMHSPs have been chosen as "pilot" sites to implement the algorithms for selected conditions. *Addresses elements of MMHC recommendation #36 (encourage the use of evidence-based pharmaceutical guidelines).*

Co-Occurring Disorders: Given the high incidence of co-occurring mental health and substance use disorders, the department has been engaged in a continuing effort to promote integrated treatment for individuals with co-occurring conditions. The "Co-Occurring Policy Academy" sponsored training for mental health and substance abuse treatment providers regarding how to address system barriers to integrated treatment, and the department has convened a state-level workgroup to tackle administrative, policy, legal and funding obstacles to integrated care. As noted previously, MDCH also funded a number of projects that are implementing the "Integrated Dual Disorders Treatment" (IDDT) model, disseminated and endorsed as a best practice approach by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). *Addresses elements of MMHC recommendation #58 (reduce barriers to treatment for people with co-occurring disorders).*

Mental Health - Criminal Justice Interface: To deal with the issue of the involvement of persons with mental illness in the criminal/juvenile justice systems, the department has continued its practice of providing "seed funds" for the establishment or enhancement of CMHSP jail diversion programs. In 2005, five programs for adult diversion and eight programs for juvenile diversion received funding. In addition, the department's Jail Diversion Policy Practice Guideline for Adults was incorporated into the MDCH-CMHSP master agreement as a contractual requirement this year, and the department released a draft "Juvenile Justice Screening, Assessment, and Diversion Policy Practice Guideline", and is negotiating its future inclusion in the MDCH-CMHSP contract. *Addresses elements of MMHC recommendation #26 (diversion).*

MDCH and CMHSPs have been working with the Department of Corrections (DOC) on the Michigan Prisoner Re-Entry Initiative (MPRI). The MPRI is a concerted, collaborative effort to assist individuals in making the transition from prison or jail back into the community, and to decrease recidivism or re-incarceration. Several CMHSPs have received grants from DOC to ensure that individuals with mental illness released from prison receive timely and appropriate follow-up mental health care. *Addresses elements of MMHC recommendation #30 (transition from detention or incarceration).*

Anti-Stigma Efforts and Recovery: The MMHC noted the need to combat stigma and support consumer recovery. The department has funded selected CMHSP anti-stigma campaigns and has recently convened a meeting of CMHSP Public Information Officers (PIOs) to coordinate anti-stigma informational and educational efforts across the state. MDCH has also distributed federal block grant funds to support dissemination of the recovery paradigm, increase peer-delivered services and "drop-in" centers, and to explore the application of "consumer-directed" care models for adults with mental illness. The department applied for, and was awarded, a CMS "Real Choice Systems Change Grant" to promote and ensure the application of recovery principles throughout the public mental health system. To launch this grant project and to increase awareness of its objectives, the department convened a Recovery Council, comprised of consumers and other system stakeholders. MDCH has provided training to CMHSPs and providers regarding how to imbed and integrate the recovery paradigm into the service delivery system. *Addresses components of MMHC Goal #1 (the public knows that mental illness and emotional disturbance are treatable and that recovery is possible)*.

Children and Families: Enhanced system collaboration for children and adolescents was a prominent theme of the Commission's Final Report. MDCH has continued to utilize federal block grant dollars to fund projects that promote and endorse adoption of "system of care" principles and practices throughout the state, and to encourage various "blended-funding" initiatives in local communities. In addition, MDCH worked with two communities on successful applications for SAMHSA "system of care" grants. Ingham County (through the Clinton-Eaton-Ingham CMHSP) will receive $6.4 million, and Kalamazoo County (through the Kalamazoo CMHSP) will receive $6.3 million, over the next six years to implement their respective system of care proposals. *Addresses elements of MMHC recommendations #20 (coordination of services to children) and #39 (blended funding streams).*

To pursue collaborative care between state departments and local agencies, MDCH, in conjunction with the Michigan Department of Human Services (MDHS), sponsored a meeting in September 2005 to explore better integration and coordination of mental health and child welfare services. The meeting was facilitated by the Bazelon Center, and was attended by representatives of MDCH, MDHS, CMHSPs and MDHS field offices. Regular follow-up meetings have been held between MDCH and MDHS with the goal of identifying pilot sites for joint purchasing of children's services by CMHSPs and county MDHS offices. *Addresses elements of MMHC recommendation #39 (joint purchasing; sustainable models of collaboration at the state and local levels).*

The department has also worked with the University of Michigan (UM) to study the service utilization patterns of children with serious emotional disturbances (SED), to determine particular areas or regions of the state where such children might be underserved, and whether SED children with *particular characteristics* are more likely to be underserved or inappropriately served. The project focused on assisting the department in identifying mental health agencies that may need technical assistance to improve practice patterns and service utilization for SED children.

Suicide Prevention: To address the critical public health problem of suicide, Michigan Surgeon General Dr. Kimberlydawn Wisdom has issued a new state blueprint for suicide awareness and prevention. The "Michigan Suicide Prevention Plan" was developed by the Michigan Suicide Prevention Coalition (MiSPC) and it provides a comprehensive approach to prevention, risk assessment and intervention. All CMHSPs were required, as part of the Annual Program Plan Submission, to report on their suicide prevention programs and their

use of the Michigan Suicide Prevention Plan. *Addresses MMHC recommendation #4 (Surgeon General should lead implementation of suicide prevention plan).*

State Psychiatric Hospitals: Most of the attention of the MMHC was focused on improving community-based services. In a parallel development, the MDCH has been engaged in an effort to identify critical issues and find solutions to the problems facing state psychiatric hospitals. Michigan's state psychiatric hospitals are grappling with problems similar to those affecting other public and non-profit safety net health providers: preservation of mission and service capacity in a precarious funding environment, weathering demand cycles and revenue fluctuations, adapting to a changing patient population (case mix and acuity), retaining staff in a competitive health care labor market, maintenance of existing physical plants, and financing needed technological infrastructure. To address these issues, MDCH established the State Hospital Improvement Project (SHIP). SHIP has been evaluating the current situation at state psychiatric hospitals; identifying the role of state inpatient care in a comprehensive public mental health system; analyzing changes in client characteristics and acuity, assessing physical plant, infrastructure, programmatic, workforce and funding needs; and formulating possible options to address these needs.

Housing: The availability of housing is a critical problem for adults with serious mental illness, whether they are exiting state psychiatric hospitals or pursuing recovery in the community. During 2005, MDCH awarded funds (from various sources) to CMHSPs and community agencies to address multiple problems related to housing and homelessness among persons with a mental, developmental or substance use related disability. PATH (Project for Assistance in Transition from Homelessness) grants were made to 19 CMHSPs to underwrite outreach and supportive services to homeless mentally ill individuals. Supportive Housing Program (SHP) grants, to provide transitional and permanent housing for homeless disabled persons, were given to 14 CMHSPs and community organizations. Finally, 18 community agencies were awarded Shelter Plus grants, to furnish various forms of rental assistance to homeless individuals with disabilities.

In addition, MDCH has been participating in a focused interagency collaboration - spearheaded by the Michigan State Housing Development Authority (MSHDA) - to identify and implement new housing options to significantly reduce and ultimately end chronic street homelessness.

These activities address elements of MMHC recommendation #61 (implement appropriate programs and supports to address homelessness).

Simplification, Data, Costing, Performance, Outcomes and Quality: Along with recommendations regarding service provision, the Mental Health Commission also advocated administrative simplification, improvements in data consistency and integrity, modifications in performance criteria and measurement, greater attention to relevant outcomes, and refinement of quality improvement strategies within the public mental health system. The department has been engaged in a number of projects, workgroups and activities to address Commission concerns about these matters.

MDCH had already established an "administrative simplification" team (composed of department staff and representatives of CMHSPs and provider organizations) prior to the Commission's Final Report. The "Administrative Simplification Process Improvement Team", continued into 2005, focused on more efficient data collection methods and processes, elimination of redundant reporting requirements, coordinating and/or combining multiple site

reviews and monitoring visits, addressing documentation issues, and clarifying the scope and objectives of MDCH financial audits. A report on the activities of the Administrative Simplification Process Improvement Team was provided to the Legislature on March 31, as required by Section 450 of the MDCH appropriations act.[3]

The department had also previously convened an ongoing workgroup (of department staff and representatives of the CMHSPs) regarding data integrity issues. The Encounter Data Integrity Team (EDIT) developed standardized service reporting criteria and devised a common methodology for calculating unit costs for each service. The team also established common definitions and costing methodologies for administrative functions. The standardization of service utilization (encounters) and cost reporting was critical to the renewal of the 1915(b) specialty waiver and the establishment of actuarially sound capitation rates for FY 2006. In response to section 460 of P.A. 154, MDCH has been working with CMHSP representatives to refine and better define costing definitions, allocation methodologies and reporting requirements for administrative costs.

Michigan's Mission-Based Performance Indicator System (MMBPIS) has already been labeled a "promising practice" by CMS[4], but in 2005, MDCH (in conjunction with other system stakeholders) revised and simplified the MMBPIS, reducing the number of indicators (eliminating ones that provided little actionable information and that had high collection costs), and reconfiguring the remaining indicators into "groupings" related to different purposes or dimensions of system performance (e.g., "dashboard" indicators to provide essential "in flight" information, "early warning" indicators, sustained performance indicators on key system objectives, etc.). All CMHSPs received information and training regarding the new MMBPIS (version 6.0) in August 2005, and the revised performance indicator system became effective in FY 05-06.

In 2004, Michigan was awarded a three-year "data infrastructure grant" by SAMHSA. The objectives of the grant were to evaluate, select and implement a uniform instrument to measure treatment outcomes for adults with serious mental illness. A steering group, composed of various system stakeholders, was established to guide the project, and to assess the acceptability, usefulness, and demand burden of various outcome measures. During 2005, training was provided to clinicians throughout the public mental health system regarding the Outcome Measurements Initiative (OMI), and subsequently nearly 150 clinicians around the state (who volunteered to participate) began field-testing four "candidate" outcome instruments. MDCH and system stakeholders are now considering which instrument should be applied throughout the public mental health system. The long-term goal of the project is to promote both the "recovery paradigm" and "outcomes management" throughout the public mental health system.

Michigan's public mental health system has a relatively evolved and extensive strategy for quality monitoring and improvement. The strategy has various components including certification, accreditation, licensing requirements, program standards, process measures (e.g. timeliness of service), local quality management plans and mandatory quality improvement projects, MDCH site visits, consumer satisfaction surveys, sentinel event reporting, grievance and appeal tracking, etc. Increasingly, elements of the quality management and improvement strategy reflect the requirements of CMS (Medicaid) and federal regulations promulgated pursuant to the Balanced Budget Act (BBA) of 1997.

[3] Available at http://www.michigan.gov/documents/450_03_31_05_121903_7.pdf
[4] See http://www.cms.hhs.gov/promisingpractices/datareadinessMI.pdf

The department has a well established, ongoing, Quality Improvement Council (QIC), with broad representatives from CMHSPs, consumers, families, advocates and other system stakeholders. In June 2005, the QIC approved a revision and refinement of the department's "Strategy for Assessing and Improving the Quality of Managed Specialty Services and Supports". The revised strategy strengthens and extends previous quality management and monitoring standards, dimensions and processes.

Along with state quality management and improvement activities, the CMHSPs designated as PIHPs under the Medicaid specialty services waiver were subject to a federally mandated "External Quality Review" (EQR) during 2005 and to a follow-up EQR during the first half of 2006. The Health Services Advisory Group conducted these external reviews.

The public mental health system is supported by multiple funding sources, each with particular eligibility criteria and service obligations/requirements. In this environment of increasing heterogeneity and complexity, *customer service activities* have emerged as a key function for CMHSPs. The customer service function includes community education, information and referral, orientation of new consumers, addressing inquiries about services, ensuring consumer participation in CMHSP workgroups and decision-oriented processes, and promoting awareness of grievance/appeal procedures and other forms of redress.

To foster a more structured, uniform approach to customer service functions and activities, the department established a "customer services improvement" workgroup, composed of departmental staff and representatives from CMHSPs that are designated Prepaid Inpatient Health Plans (PIHPs). The workgroup has developed guidance to CMHSPs/PIHPs regarding "best practices" in customer service functions and will begin training on customer services standards in September 2006.

These activities address elements of MMHC recommendations #18 (strengthen the MDCH quality management system), #33 (standard setting), and #34 (administrative costs).

Structure and Organization: The MMHC called for a thorough reassessment of the structure, organization, role designations and distribution of functions among the state, regional entities, local CMHSPs and organized provider groups. To further explore structural change options and implications, the department held meetings with system stakeholders in December 2005 and February 2006. In these meetings, MDCH offered a perspective on system reorganization opportunities, and how such restructuring might be combined with other changes to simplify system administration, create efficiencies and reduce operational variance. The meetings have afforded stakeholders a chance to absorb and react to the MDCH perspective, and suggest alternative models for restructuring. *Addresses elements of MMHC recommendation #31 (system structure).*

Work of the Interagency Directors Group: In October 2005, the Interagency Directors' Group (IDG) received a briefing on particular Commission goals, findings and recommendations that require attention, involvement and specific action by other state agencies and departments. The Governor charged the IDG with responsibility for addressing the 18 Commission recommendations that require coordinated action by multiple state agencies. The IDG has been developing strategies to address each of these recommendations for coordinated, concerted, state action.

Work of the Advisory Council on Mental Illness: Recommendation No. 37 of the Final Report suggested that MDCH *"…expand the charge of the current MDCH Advisory Council on Mental Illness to assist the MDCH director and the governor with implementation of the commission's recommendations*[5]. The Advisory Council on Mental Illness (ACMI) is an advisory body required under federal mental health block grant legislation. MDCH Director Olszewski subsequently expanded the charge of the ACMI beyond the federal parameters to include responsibility for particular implementation activities, and ACMI established workgroups to address access, eligibility standards, and service guidelines (*MMHC recommendation #8*), appeal and grievance mechanisms (*MMHC recommendations #46 and #47*), and the establishment of secure residential settings (*MMHC recommendation #14*). The ACMI recently provided Director Olszewski with several proposals on implementation of Commission recommendations related to these items.

UPDATED PLAN FOR IMPLEMENTING RECOMMENDATIONS OF THE MMHC

In this section, we have provided a *general description* of planned steps and activities to further implement the recommendations of the MMHC. Implementation initiatives and measures are organized around Commission goal areas, and planned actions that address recurrent themes and suggestions (those that appear under multiple goal areas of the MMHC Report) have been grouped together for ease of exposition.

Public Education and Anti-Stigma

Surveys conducted over the past decade suggest that public views regarding mental illness have changed over the past 40 years. Americans are more knowledgeable regarding the nature and prevalence of mental illness, are more aware that effective treatments exist, and are apparently more willing to seek care for mental and emotional problems. However, despite these broader views and increased knowledge, survey responses indicate that people are still disinclined to have social contact or connections with persons who have (or have had) a mental illness (social avoidance), and that more people today associate or link mental illness with violent or dangerous behavior. The authors of a recent book on the well-being of persons with mental illness concluded that "…the public holds a broader yet in some ways more stigmatized view of mental illness now than it did in the 1950s."[6]

The MMHC Report recommended improved efforts to inform and educate the public regarding mental illness, and to combat misperceptions and stereotypes regarding these disorders. As noted in the previous section, MDCH has been working with CMHSPs over the last year to develop a more consistent and unified anti-stigma message, and MDCH has also provided grants to local agencies for public information and education initiatives.

In the next year, MDCH plans to expand its anti-stigma efforts by:

- Promoting the use of selected programs and models identified by the federal Substance Abuse and Mental Health Administration (SAMHSA) through its "Resource Center to Address Discrimination and Stigma" (ADS Center). MDCH and CMHSP representatives will attend a SAMHSA sponsored training to learn how to best utilize and employ the resources of the ADS Center for a state anti-stigma campaign. SAMHSA is also providing technical assistance and information to states regarding the development of

[5] Michigan Mental Health Commission Final Report, Page 44
[6] Better But Not Well: Mental Health Policy in the United States Since 1950; by Richard Frank and Sherry Glied; Page 137

anti-stigma "public service advertisements" (PSAs), and methods to solicit media outlets to air these PSAs.

- Convening a small planning group of stakeholders to plan and execute a statewide conference or "summit" on stigma, and to identify possible sources of funding/support for a continuing public education/anti-stigma campaign.
- Utilizing the newly established Recovery Council to advise MDCH regarding how to best link the promotion of the recovery paradigm to anti-stigma efforts.

Behavioral and Health Screening

The need for earlier screening, better recognition and prompt intervention was a theme that runs through many recommendations of the MMHC. It was noted that the state's health, human services and educational systems often fail to identify a significant number of children and adolescents with substantial mental health problems or disorders. Moreover, while current *general screening* efforts to detect emotional problems in children and adolescents are inadequate, recent research (both within Michigan and nationally) have demonstrated the value of implementing *specific protocols for the detection and early intervention of psychosis* in adolescent/young adult populations.

For adult populations, various studies and surveys have confirmed the high prevalence – and inadequate recognition - of substance use disorders among adults with a serious mental illness. Still other investigators have identified the increased morbidity and mortality associated with serious mental illness, due largely to preventable (but undetected or untreated) medical conditions.

Over the next year, MDCH plans to improve screening, recognition, detection and intervention in these areas by:

- Disseminating information to health, human services and educational agencies on behavioral health screening tools and methods for children and adolescents.
- Publicizing research findings and model programs on early detection, prevention and treatment of psychosis, and soliciting funding (through various foundations or grantmakers) for pilot implementation of such model programs.
- Requiring all agencies and programs funded through the public mental health system to establish, develop, and maintain the capacity to recognize and treat co-occurring mental health/substance use disorders.
- Provide information regarding, and develop treatment guidelines/standard of care protocols, related to the screening, detection, care coordination (linkage) and ongoing monitoring of the health status of individuals with serious mental disorders.

Consistency in Eligibility Determination and Standardized Service Array

The current public mental health system is supported through multiple funding sources that confer differential access rights and service obligations. General fund allocations, Medicaid capitation payments, the MiChild Program and the Adult Benefit Waiver (ABW) have particular eligibility requirements and service use parameters. The complexity inherent in these various funding mechanisms is further confounded by different "interpretations" of eligibility and service obligation requirements made by different CMHSPs or PIHPs.

To address the MMHC's concerns regarding such variance, MDCH is working with various stakeholders to provide more uniform and consistent guidance on eligibility, and to identify the array of services or programs required under statute, rule, and federal or other funding source obligations. Over the next year, MDCH will:

- Support legislation recommended by the Advisory Council on Mental Illness (ACMI) regarding uniform statewide criteria for determining eligibility and priority for mental health services provided through state general fund allocations.
- Work with the Access Workgroup commissioned through the Michigan Association of Community Mental Health Boards (MACMHB) to develop standard interpretations of the access and benefit requirements of different "defined benefit" arrangements (e.g., Medicaid 1915b waiver, Medicaid 1915c waiver, Children's DD Waiver, Children's SED waiver, MiChild, ABW, etc.).
- Ensure, through the MDCH site review process, the availability of services and programs required under various statutes, regulations and/or benefit programs.
- Convene a workgroup to assess the availability, adequacy and geographic proximity of inpatient psychiatric and structured residential services across the state.

Mental Health – Justice System Interface

Prior to the recommendations of the MMHC regarding the interaction between the mental health and justice systems, MDCH had initiated efforts to ensure jail diversion programs throughout the state, through contractual provisions, site reviews, block grant funding for programs and dissemination of practice guidelines. Since the issuance of the Final Report of the MMHC, there has been increased attention to improving coordination between the mental health system and the police, the courts, correctional and detention facilities and community corrections. However, there is still much to do, and certain legal, organizational and funding arrangements pose obstacles to greater progress. The decentralized nature of Michigan's public mental health system, and the complexities of current funding arrangements, makes it difficult for MDCH to promote uniform policies and practices throughout the state.

A larger percentage of the populations at state hospitals and centers have some past forensic involvement. As these individuals move back into the community, local monitoring and care management arrangements are often inconsistent or inadequately implemented. MDCH lacks field staff to review these arrangements and to ensure adequate implementation. And, while MDCH operates the Corrections Mental Health Program (CMHP) under a contract with the Michigan Department of Corrections, MDCH does not have an appropriation line to finance community care for individuals that have been served through the CMHP, but who are scheduled for parole or release. Financing for some "post-incarceration" community care is available through the Michigan Prisoner Re-Entry Program, but this funding goes directly to selected community agencies. Finally, although jail diversion, jail mental health care, juvenile offenders and detection of mental disorders, and mental health courts (both adult and for juveniles) are critical local issues, MDCH lacks dedicated personnel to provide leadership on these important issues.

While MDCH will continue to emphasize current jail diversion, law enforcement training, and prisoner re-entry initiatives, the department will also attempt to address the larger "structural" barriers noted above:

- MDCH will develop an organizational, operational and financing plan that more clearly aligns the department's forensic, risk management, release monitoring, community linkage and practice responsibilities, and disseminate this plan for review and discussion.

Structure, Funding, and Accountability

While the Final Report of the MMHC stresses certain value and ethical dimensions that are the foundation of a "public" mental health system, the Commission also was interested in issues that fall within a "managerial" perspective on mental health care. Specifically, the Commission made recommendations related to the structure, organization, funding, performance and accountability of the public mental health system.

The Commission called for a clarification of roles and responsibilities between various components of the public mental health system. As noted above, MDCH has held two large stakeholder forums to explore the matter of system structure. These "re-engineering" discussions have revealed different perspectives regarding the proper balance of state, regional, local CMHSP, organized provider systems and contract agencies responsibilities.

From a practical standpoint, the regional entities – the PIHPs – are gradually absorbing administrative functions that require economies of scale, while preserving the organization and delivery of services as matters of local decision and responsibility. The PIHPs have joined together in a consortium to standardize certain practices and to develop a common approach to emerging issues, such as health information technology and electronic medical records. The PIHPs have become the fulcrum for system adoption of selected evidence-based practices (EBPs) and for the implementation of mandated quality improvement and service coordination initiatives.

In addition to structural considerations, the MMHC was interested in standardizing reporting of administrative costs and setting ranges for acceptable expenditures in this area. Considerable progress is being made in standardizing administrative cost reporting due, in large part, to boilerplate language (section 460) of the MDCH appropriation act (PA 154) that requires greater standardization in the identification, classification, allocation and reporting of administrative costs.

Some of the Commission's suggestions related to funding enhancements have not yet been adopted, and require legislative support and endorsement.

During the next year, MDCH will further address Commission recommendations on structure, organization and accountability by:

- Further examining current structural arrangements, and issuing a report (target date: April 2007) that describes the benefits (and costs) of alternative structural configurations.
- Working with the "Standards Group" established by the PIHPs to regionalize and standardize the operation and performance of certain functions.
- Continue to examine methods that might improve the distribution of the general fund appropriations, utilizing the "Funding Equity Group" established per section 462 of PA 154. A status report on funding equity considerations will be provided to the legislature as required.

- Revising the position description of the Psychiatric/Medical Director of the Mental Health and Substance Abuse Administration of MDCH, to enhance the role of the Psychiatric/Medical Director in providing clinical leadership and direction to the public mental health system.

Service Integration and Cross-System Coordination

The Interagency Directors' Group (IDG) has been working on many recommendations related to cross-system collaboration, and will soon provide a status report on these implementation efforts.

MDCH will continue efforts to better align public mental health care with other ancillary services and programs by:

- Continuing the workgroup formed by MDCH and the MDHS to coordinate services to children, to expand mental health services to children in foster care, and to devise methods for joint purchasing of behavioral services by the two state agencies.
- Active participation and involvement in the MSHDA-led initiative to end chronic street homelessness.
- Promotion of various local models that better coordinate, supply or integrate mental health with the delivery of physical health care.
- Participation in a study (through the National Research institute, a subsidiary of the National Association of State Mental Health Program Directors) of mental health related spending throughout state government (MDCH and all other state agencies and departments). Such participation hinges (in part) on the availability of internal resources to staff such an undertaking
- Identify and disseminate best practice models for CMHSP coordination and collaboration with hospital emergency departments.

User Involvement

The department's efforts to increase user involvement revolve around the following active initiatives:

- The formation of the Recovery Council, with its mandate to review MDCH policies, procedures, and practices and determine if they conform with the principles of a recovery-oriented system of care.
- Continued training and certification of peer-specialists, expanding the supply of certified specialists and enlarging the role of peers in CMHSP operations.

ESTABLISHMENT OF SECURE RESIDENTIAL FACILITIES

The MDCH has completed a limited feasibility study regarding the establishment of secure residential facilities (fewer than 16 beds). The ACMI has also made recommendations regarding such facilities, and there have been legislative workgroups devoted to this topic.

At the present time, few states utilize “locked” residential facilities, apparently due to the legal complexities associated with such arrangements. Most states that have residential facilities for consumers with certain high-risk characteristics describe their programs as “structured” (e.g., high staff to consumer ratios; certification of the facility; expectations of extensive in-facility programming, etc.) rather than “secure”.

In Michigan, if the establishment of a “secure” residential setting means a “locked” facility, it would appear that changes need to be made in the statute and rules regarding the licensing of dependent care settings and the certification of specialized residential programs. Due to the constraints on personal liberty that such a facility implies, it would seem desirable for such residential programs to be developed and operated through the state, and that consumers are assigned to such arrangements only pursuant to a court-order (i.e. alternative treatment order) or other legal directive (e.g., parole requirement).

The costs associated with such facilities involve the start-up or capital costs in establishing such facilities (or in converting existing facilities to a high structure environment), and on-going operational costs. Some of the services provided in such living arrangements could be covered by Medicaid (for Medicaid eligible recipients, if the facility is under 16 beds), providing some revenue to address ongoing operational costs.

MDCH is still examining the likely benefits – relative to the costs - of such arrangements. It appears that the most promising use of a secure residential setting would be for certain individuals in our state hospitals that have serious or significant past forensic involvement, and/or for seriously mentally ill individuals who are being released or paroled from a state correctional facility. If the establishment of such facilities decreases the need for state hospital utilization, or if it provides a more structured “step-down” setting for both forensic patients or seriously mentally ill individuals released or paroled from the corrections system, there are potential significant cost-savings and safety considerations that might offset the expense of developing and operating such residential settings. However, on the cost side, there are (at present) no specific estimates of whether (or how much) such housing options would reduce state hospital utilization, or of the possible (range) cost-offsets of the proposed arrangements.

ESTABLISHMENT OF SPECIALIZED MENTAL HEALTH COURT PROGRAM

The Center for Court Innovation has noted that:

> “The past decade has been a fertile one for court reform. All across the country, courts - in concert with both government and community partners - have been experimenting with new ways to deliver justice. This wave of innovation goes by many names and takes many forms. Domestic violence court in Massachusetts. Drug court in Florida. Mental health court in Washington. Community court in New York. Each of these specialized courts targets different kinds of concerns in different kinds of places. And yet they all share a basic organizing theme — a desire to make courts more problem-solving and to improve the kinds of results that courts achieve for victims, litigants, defendants and communities.“

Mental health courts as a variant of problem-solving courts have steadily expanded over the past four years, fueled by federal grant funds from the Bureau of Justice Assistance. These grants have gone to various municipal and circuit-level courts around the country that have

specifically applied for funding. MDCH is not aware of any federally-funded mental health courts in Michigan, although there are some courts in the state that appear to function (e.g., special docket, alternative dispositions, etc.) as mental health courts, and which seem to have the "essential attributes" of a mental health court as defined by the Bureau of Justice Assistance.

If established in certain jurisdictions, mental health courts would likely be a valuable component of an overall community effort to address the issue of persons with serious mental illness entering the criminal justice system, particularly if such courts were used as a component of pre-booking diversion efforts. It would complement jail diversion programs, law enforcement training, and prisoner re-entry activities that are already active or underway. There exists a great deal of literature regarding the establishment and operation of a mental health court, which would cut the development time for creation of such a court.

The major obstacles to the establishment (and retention) of a mental health court is start-up funding (which might be obtained from federal sources if a locality were to apply), sustainability (funding to maintain the specialized court once initial funding sources have been phased out) and the possible diversion of existing mental health funding/services from non-offenders to support treatment/interventions needed by individuals involved with the mental health court. Another consideration is the need to develop a statutory framework for mental health courts (similar to that which exists for drug courts) to ensure that these courts are operated under uniform standards, guidelines and criteria.